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SAN BERNARDINO COUNTY

Department of Behavioral Health
Substance Use Disorder and Recovery Services

San Bernardino County DBH-SUDRS CalOMS Annual Update

First Name		**Last Name**	
Counselor Name		**Date**	
Client ID			

CalOMS Annual Update

Annual Update Date

Please enter the day the annual update is completed**.** _____

Current First Name

Please enter the client's current first name if different from the birth name. _____
Please enter "**99904**" if the client is unable to provide an answer.

Current Last Name

Please enter the client's current last name if different from the birth name. _____
Please enter "**99904**" if the client is unable to provide an answer.

Social Security Number

Please enter the client's social security number. _____
Please enter "**99900**" to indicate that the client declines to state their social security number
Please enter "**99904**" to indicate that the client is unable to answer.

Zip Code at Current Residence

Please enter the client's current zip code. _____
Please enter "**00000**" to indicate that the client is homeless and update the **Current Living Arrangements** on the **Family/Social Data** section accordingly.
Please enter "**99900**" to indicate that the client declines to state their ZIP code.
Please enter "**99904**" to indicate that the client is unable to answer.

Disability

Please select the client disability (check appropriate box(es)):

☐None
☐Visual
☐Hearing
☐Speech
☐Mobility
☐Mental
☐Developmentally Disabled
☐Other
☐Client declined to state
☐Client unable to answer

Record to be Submitted

Please select the annual update record to be submitted (check appropriate box):
☐Annual Update ☐Resubmission of Annual Update ☐Deletion of Annual Update ☐ None

Annual Update Number

Please enter the annual update number. _____
*If a user overrides the Annual Update Number, when doing the Cal-OMS Submission, the Annual Update number used will be whatever the user entered. If no change is made to the Annual Update Number, when doing the subsequent Cal-OMS Submission the Annual Update Number will increase.

Consent

Please select **Yes or No** if the client has given consent to be contacted in the future (check appropriate box):
☐ Yes ☐ No

Alcohol and Drug Use

Primary Drug
Please select the client's primary drug of use (check appropriate box):
If **Other (Specify)** is selected, enter the name of the client's primary drug in the **Primary Drug Name**.

Ask: What is your primary alcohol or other drug problem?

☐Alcohol
☐Barbiturates
☐Cocaine/Crack
☐Ecstasy
☐Heroin
☐Inhalants
☐Marijuana/ Hashish
☐Methamphetamines
☐Non-Prescription Methadone
☐None
☐Other (specify) _____
☐Other Amphetamines
☐Other Club Drugs
☐Other Hallucinogens
☐Other Opiates and Synthetics
☐Other Sedatives or Hypnotics
☐Other Stimulants
☐Other Tranquilizers
☐Over-the-Counter
☐OxyCodone/OxyContin
☐PCP
☐Tranquilizer (Benzodiazepine)

Primary Drug Frequency
Please enter the drug use frequency.

Ask: How many days in the past 30 days have you used your primary drug of abuse? _____

Primary Drug Route of Administration
Please select the client's primary drug route (check appropriate box):

Ask: What usual route of administration do you use most often for your primary drug of abuse?

☐Oral
☐Smoking
☐Inhalation
☐Injection (IV or intramuscular)
☐None or Not Applicable
☐Other

Secondary Drug
Please select the client's secondary drug of use (check appropriate box):
If **Other (Specify)** is selected, enter the name of the client's secondary drug in the **Secondary Drug Name.**

Ask: What is your secondary alcohol or other drug problem?

☐Alcohol
☐Barbiturates
☐Cocaine/Crack
☐Ecstasy
☐Heroin
☐Inhalants
☐Marijuana/ Hashish
☐Methamphetamines
☐Non-Prescription Methadone
☐None
☐Other (specify) _____
☐Other Amphetamines
☐Other Club Drugs
☐Other Hallucinogens
☐Other Opiates and Synthetics
☐Other Sedatives or Hypnotics
☐Other Stimulants
☐Other Tranquilizers
☐Over-the-Counter
☐OxyCodone/OxyContin
☐PCP
☐Tranquilizer (Benzodiazepine)

Days of Secondary Drug Use in the Last 30 Days
Please enter the drug use frequency.

Ask: How many days in the past 30 days have you used your secondary drug of abuse? _____

In the **Secondary Drug Route of Administration**
Please select the client's secondary drug route (check appropriate box):

Ask: What usual route of administration do you use most often for your secondary drug of abuse?

☐Oral
☐Smoking
☐Inhalation
☐Injection (IV or intramuscular)
☐ None or Not Applicable
☐Other

Days of Alcohol Use in the Last 30 Days
Please enter the frequency of alcohol use in the last 30 days. This field is used when the primary and secondary drugs are not alcohol.

Ask: How many days in the past 30 days have you used alcohol? **_____**
***If the participant's primary or secondary drug problem is alcohol, enter 99902.**

IV Use
Please enter the frequency of the IV use.

Ask: How many days have you used needles to inject drugs in the past 30 days? _____

Employment

Employment Status
Please select the client's employment status (check appropriate box):

Ask: What is your current employment status?

☐Employed Full Time (35 hours or more)
☐ Employed Part Time (less than 35 hours)
☐Unemployed Looking for Work
☐ Unemployed – (Not seeking)
☐ Not in the labor force (Not seeking)

Work Past 30 Days
Please enter the number of work days the client has had in the past 30 days.

Ask: How many days were you paid for working in the past 30 days? _____

Enrolled in School
Please select the client's enrollment status (check appropriate box):

Ask: Are you currently enrolled in school?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Enrolled in Job Training
Please select the client's job training status (check appropriate box):

Ask: Are you currently enrolled in a job training program?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Highest School Grade Completed
Please enter the client's highest school grade completed.

Ask: What is the highest school grade you completed? _____
Enter "99900" to indicate that the client declines to state
Enter "99904" to indicate that the client is unable to answer.

Criminal Justice

Number of – Please enter the number of times the client has been involved with the specified activity in the last 30 days.

Ask: How many times have you been arrested in the past 30 days? _____

Ask: How many days in the past 30 days were you in jail? _____

Ask: How many days has the client been in prison in the past 30 days? _____

Medical/Physical Health

Last 30 Days
Please enter the number of times the client has been involved with the activity in the last 30 days.

Ask: How many times have you visited an emergency room in the past 30 days for physical health problems? _____

Ask: How many days have you stayed overnight in a hospital in the last 30 days for physical health problems? _____

Ask: How many days in the past 30 days have you experienced physical health problems? _____

Pregnant At Admission
If discharge or annual update (check appropriate box):

Ask: Were you pregnant at any time during treatment?
☐ No ☐ Not Sure/Don't know ☐ Yes

HIV Tested
Please select the client's HIV testing status and results (check appropriate box):

Ask: Have you been tested for HIV/AIDS?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer
Ask: Did you receive the results of your HIV/AIDS test?
☐ No ☐ Yes ☐ Client declined to state ☐ Client unable to answer

Mental Illness

Mental Illness
Please select **Yes, No or Not Sure/Don't Know** if the client has mental illness (check appropriate box):

Ask: Have you ever been diagnosed with a mental illness?
☐ No ☐ Not Sure/Don't know ☐ Yes

Emergency Room Use/Mental Health

Ask: How many times in the past 30 days have you received outpatient emergency services for mental health needs? _____

Psychiatric Facility Use
Please enter the number of days in the last 30 days the client has stayed for more than 24 hours in a hospital or psychiatric facility.

Ask: How many days in the past 30 days have you stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? _____

Mental Health Medication
Please select the client's mental health prescription medication use in the last 30 days (check appropriate box):

Ask: In the past 30 days, have you taken prescribed medication for mental health needs?
☐ No ☐ Yes ☐ Client unable to answer

Family/Social

Social Support
Please enter the number of days in the last 30 days the client has participated in social support recovery activities.

Ask: How many days have you participated in any social support recovery activities in the past 30 days such as 12-step meetings, other self-help meetings, religious/faith recovery or self-help meetings, meetings of organization other that those listed above, interactions with family members and/or friend support of recovery? _____

Current Living Arrangements
Please select the client's current living arrangement (check appropriate box):

Ask: What are your current living arrangements?
☐ Homeless
☐ Independent Living
☐ Dependent Living

Living with Someone
Please enter the number of days in the last 30 days the client has lived with someone who uses alcohol or drugs.
Ask: How many days in the past 30 days have you lived with someone who uses alcohol or other drugs? _____

Family Conflict Last 30 Days
Please enter the number of days in the last 30 days the client had serious conflicts with their family.

Ask: How many days in the past 30 days have you had serious conflicts with members of your family? _____

Number of Children
Please enter the number of children associated with the client.

Ask: How many children do you have aged 17 or younger (birth or adopted) whether they live with you or not? _____

Ask: How many children (birth or adopted) do you have aged five years or younger? _____

Ask: How many of your children (birth or adopted) are living with someone else because of a child protection court order? _____

Ask: If you have children (birth or adopted) living with someone else because of a child protection court order, for how many of these children aged 17 or under have your parental rights been terminated? _____